NOTICE OF WORKERS' COMPENSATION INSURANCE

STATE OF MAINE
WORKERS' COMPENSATION BOARD
27 STATE HOUSE STATION
AUGUSTA, MAINE 04333-0027

1. NAME OF INSURER: _____ ADDRESS: _____
2. UIAN (STATE TAX#): _____ FEIN (FEDERAL TAX #): _____ NCCI #: _____
3. Complete name and address of employer as shown on policy. (Must show correct trade name or corporate name as registered with proper authority). Please use additional sheets if necessary.

   MAINE EMPLOYER NAME (DBA): _____

   ADDRESS: _____
4. OWNER'S NAME: _____ ADDRESS: _____
5. NEW ☐ RENEWAL ☐ REINSTATEMENT ☐ ENDORSEMENT ☐ CANCELLATION ☐

6. DATE OF COVERAGE: FROM: _____ TO: _____

   This coverage remains in effect in accordance with this filing until the company notifies the Maine Workers' Compensation Board that such coverage is terminated by cancellation pursuant to the provisions of the Act.
7. POLICY NUMBER: _____
8. INDIVIDUAL ☐ CO-PARTNERSHIP ☐ CORPORATION ☐ ESTATE ☐ ASSOCIATION ☐ MUNICIPALITY ☐ OTHER ☐

9. ALL LOCATIONS IN MAINE WITH COVERAGE: _____
10. NATURE OF BUSINESS COVERED BY THIS POLICY (LIST TYPE OF BUSINESS – NO CODES):

    _____
11. **TERMINATION NOTICE**

    DATE OF MAILING: _____

    Please note that coverage has been terminated as of _____

    REASON: _____

    If termination occurs on policy expiration date, **CANCELLATION NOTICE DOES NOT NEED** to be sent to the Board
12. **REINSTATEMENT**

    DATE : _____

    This is to inform you of the withdrawal of termination notice which was to have been effective on _____
13. **ENDORSEMENT**

    EFFECTIVE DATE: _____ DATE: _____

It is agreed that as of the effective date hereof policy is amended as follows:

_____

_____